MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 54a

CERTIFICATE OF DEATH

67356

Reg. Dist. No. 4336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Delmar (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or Town Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Chestnut (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry Gordon Allen

3. (b) Social Security Number 717-07-9201

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Fannie Ruth Allen

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug 12 - 1894

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Conductor

11. Industry or business Railroad

FATHER 12. Name James H. Allen Sr.

FATHER 13. Birthplace Crest, Va

MOTHER 14. Maiden name Estelle Swift

MOTHER 15. Birthplace Fredericksburg, Va

16. Informant Mrs Henry G. Allen

Address Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-45 (month) (day) (year)

Cemetery or crematory Parsons

Location Salisbury Md.

18. Funeral director W. S. Grandcq

Address Delmar, Del

19. July 9th 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th 1945 at 3 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 7 1945 and that I last saw h... alive on July 7 1945

Immediate cause of death	DURATION
Coronal thrombosis with Respiration Bronchopneumonia	12 hours
Due to Fracture of Brain	3 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Lynch M. D. or other

Address Delmar Del Date signed July 8/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07357

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH:

County: Wicomico

City or town: Sharptown - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Sharptown - Mardela Road

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Sharptown - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sharptown - Mardela Road
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: James O. Allen

3.(b) Social Security Number: 218-14-2527

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elsie Allen

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): February 17, 1897

8. AGE:

Years	Months	Days	If less than one day
48	4	26	...hrs. ...min.

9. Birthplace: Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation: Day laborer / Farm

11. Industry or business

FATHER
12. Name: Fred Polk
13. Birthplace: Bridgeville, Delaware

MOTHER
14. Maiden name: Martha J. Allen
15. Birthplace: Wicomico County, Maryland

16. Informant: Ruby Stanley
Address: Sharptown, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16, 1945 (month) (day) (year)

Cemetery or crematory: San Domingo Cemetery

Location: Near Sharptown, Maryland

18. Funeral director: J. T. Frampton and Son

Address: Federalsburg, Maryland

19. July 14 1945 (Date rec'd by registrar) Walter G. Mason Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1945 to July 13 1945 and that I last saw him alive on July 12 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: H. S. Kuhlmann M. D. or other

Address: Sharptown Md Date signed: 7/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07358

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 year
Hospital, Institution, or street address where death occurred: R.D. #4. (Mt. Hermon Road)
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #4. (Mt. Hermon Rd) (If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Ruth Elizabeth Blackeson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife Richard Blackeson
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Sept. 18-1876

8. AGE: Years	Months	Days	If less than one day
68	9	13	..... hrs. ..... min.

9. Birthplace Princess Furnace Md (Town, county, and state)
10. Usual occupation Home wife
11. Industry or business At Home
FATHER 12. Name William Tamar
13. Birthplace Cecil Co. Md.
MOTHER 14. Maiden name Johnson
15. Birthplace Cecil Co. Md.
16. Informant Mr. Richard Blackeson
Address R.D. #4. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof July. 9-1945 (month) (day) (year)
Cemetery or crematory Asbury Church Cem.
Location Near Hebbertown Delaware
18. Funeral director Hollowa & C. Walter K. Holloway
Address Salisbury maryland
19. 7/7/45 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1945, at 2.15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to July 1 1945
and that I last saw h.. alive on July 1 1945

Immediate cause of death	DURATION
Chr. Valv. Heart.	6 mos
Due to Chr. Inf. Nephritis	2 yrs
Due to Arter. Sclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W D Davey M.D. M. D. or other
Address ..... Date signed 7/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

07359

★ Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution or street address where death occurred: P. B. Hoyt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1025 Allen St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ernest Blades

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Blades

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Feb. 18-1878

8. AGE: Years 67 | Months 4 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Worcester Co. R.D. Pocomoke Md.
(Town, county, and state)

10. Usual occupation: House Painter

11. Industry or business

FATHER — 12. Name: Saunder Blades

13. Birthplace: R.D. Pocomoke Md.

MOTHER — 14. Maiden name: Arintha Davis

15. Birthplace: R.D. Pocomoke Md.

16. Informant: Mr. Randall S. Blades

Address: R.D. #2 Norristown Pa.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 18-1945 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Maryland

18. Funeral director: Hellman & Co. Walter R. Hellman

Address: Salisbury Maryland

19. 7/17/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 19 45 at 3 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 45 to July 15 19 45 and that I last saw him alive on July 15 19 45

Immediate cause of death	DURATION
Coronary Occlusion, Acute	
Due to: Coronary Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. Rivers Hanson, M.D. M. D. or other

Address: Salisbury, Md. Date signed 7/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07360

Reg. Dist. No. 999

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since April 2, 1940
Hospital, institution, or street address where death occurred:
E. Shore Tuberculosis Sanatorium
How long in hospital or institution? Since April 2, 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Chester, Maryland
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Bradshaw, Rachel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John C. Bradshaw
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): December 21, 1867

8. AGE: Years	Months	Days	If less than one day
77	7	10	hrs. min.

9. Birthplace: Tylerton, Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Steward H. Evans
13. Birthplace: Tylerton, Maryland

MOTHER
14. Maiden name: Rachel Evans
15. Birthplace: Tylerton, Maryland

16. Informant: Edison Bradshaw
Address: Chester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug-3, 1945 (month) (day) (year)
Cemetery or crematory: Crisfield Cemetery
Location: Crisfield Maryland
18. Funeral director: H. Harvey Bradshaw
Address: Crisfield, Maryland

19. 8/1/45 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 45 at 9:50p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1940 19 to 7/31/45 19
and that I last saw her alive on 7/31/45 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul [illegible] M.D. M. D. or other
Address: Salisbury Md. Date signed 8/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-a)

CERTIFICATE OF DEATH

07361

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: 109 W. Phila. ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 W. Phila. ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida Alice Buttinghamm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Bergan N. Buttinghamm Dead
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) March 9-1872

8. AGE:

Years	Months	Days	If less than one day
73	4	10	..... hrs. ..... min.

9. Birthplace: Salisbury Md
(Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: John L. Baker
13. Birthplace: Bethel Delaware

MOTHER
14. Maiden name: Maria Middleton
15. Birthplace: R.D. Parsonsburg Md.

16. Informant: Mrs. Esther B. Bedsworth
Address: 109 W. Phila. ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24-1945 (month) (day) (year)
Cemetery or crematory: Parsons Assn.
Location: Salisbury Maryland.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md

19. 7/23/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19th 1945 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to July 18 1945
and that I last saw h.. alive on July 18 1945

Immediate cause of death: Adenocarcinoma of Cervix & Metastases — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. M. Dingman M. D. or other
Address: Salisbury Md. Date signed 7/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

67362

★ Reg. Dist. No. 338

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: RURAL, Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louise Frances Brittingham

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lloyd Brittingham
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): July 4, 1900
8. AGE: Years: 45 Months: 0 Days: 9 If less than one day: hrs. min.
9. Birthplace: RURAL, Pocomoke - Worcester, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Purnell Dennis
13. Birthplace: Rural, Pocomoke, Md

MOTHER
14. Maiden name: Minnie C. Fisher
15. Birthplace: Rural, Pocomoke, Md.

16. Informant: Mrs Samuel Bacon
Address: 506 Young St. Pocomoke, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof July 16 1945 (month) (day) (year)
Cemetery or crematory: St. James Cemetery
Location: Rural, Pocomoke, Md

18. Funeral director: A. Harvey Bradshaw
Address: 401 Market St. Pocomoke Md

19. July 18 1945 (Date rec'd by registrar) Lorraine C. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13th 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Burned by fire	5 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: July 13 '45
Where did injury occur? Pocomoke City (City or town) Worcester (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Burned by fire Injured at work? Yes

SIGNATURE: John L. Riley M.D. Med Examiner
M. D. or other
Address: Snow Hill Md. Date signed: 7/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

07363

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 1 mo
Hospital, institution, or street address where death occurred: 223 E. Isabella, street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 223 E. Isabella, st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Calloway

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nancy Jane Calloway
6.(c) If alive, give age: 83 years
7. Birth date of deceased (mo., day, yr.): June 20-1857

8. AGE: Years	Months	Days	If less than one day
88	0	25	...hrs. ...min.

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Miller

FATHER
12. Name: Benjamin Calloway
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Hastings
15. Birthplace: Sussex Co. Del.

16. Informant: Mr. Benjamin R. Calloway
Address: East Salisbury Fire House, Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. 7/17/45 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15th 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 1945 to July 15 1945 and that I last saw him alive on June 30 1945

	DURATION
Immediate cause of death: Valvular Heart Disease	Years
Due to:	
Due to:	
Other conditions: Hypertrophy Prostate	Years

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hiram R Mann, M. D. or other
Address: Salisbury Md Date signed 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

67364 333

★ Reg. Dist. No. 25B

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 Truitt St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joshua Olin Chance

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Kattie M. Chance

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
53	7		hrs. min.

9. Birthplace Queenannes County

(Town, county, and state)

10. Usual occupation retired storekeeper

11. Industry or business

FATHER

12. Name Joshua S. Chance

13. Birthplace Queenannes County

MOTHER

14. Maiden name Kate Melvin

15. Birthplace Queenannes County

16. Informant Mrs. Kattie Chance

Address 130 Truitt St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15-1945 (month) (day) (year)

Cemetery or crematory Centreville, Md.

Location Centreville, Md.

18. Funeral director Edgar L. Lane

Address Church Hill, Md.

19. July 17 1945 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/10 1945 to 7/13 1945 and that I last saw h... alive on 7/10 1945

Immediate cause of death	DURATION
Cardiac Hemorrhage	1 hr.
Due to	
Due to	
Other conditions Angina	1 hr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James R Mann M. D. or other

Address Salisbury Md Date signed 7/13/45

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0736.5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1200

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Fairmont
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Chelton, Mrs Edith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Joseph Chelton
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Nov. 6, 1866

8. AGE: Years	Months	Days	If less than one day
78	8	16	..... hrs. ..... min.

9. Birthplace Somerset Co Md (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name unknown Somerset
13. Birthplace " - Md.
MOTHER 14. Maiden name " - Bozman
15. Birthplace " - Md.
18. Informant Mrs. Marie Elliott
Address Sevren, Md.
17. Burial Date thereof July 26/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Presbyterian
Location Princess Anne
18. Funeral director Harry B. Miles
Address Upon Fairmount
19. 7/26/45 1946 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 19 45 at 7 45 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-19 19 45, to 7-22 19 45
and that I last saw h... alive on 7-22 19 45

	DURATION
Immediate cause of death acute gastro enteritis	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of No
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. S. Rackemann M. D.
M. D. or other
Address Salisbury Md Date signed 7/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-E)

CERTIFICATE OF DEATH

07366

Reg. Diat. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: Erie
City or town: Buffalo
(If outside city or town limits, write RURAL and give nearest town)
Street No. 71 Hendy St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Dorothy Coyne

3.(b) Social Security Number: ✓

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Coyne
6.(c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): Nov. 27, 1907
8. AGE: Years: 37 Months: 7 Days: 20 If less than one day: ...hrs. ...min.
9. Birthplace: Alden, New York (Town, county, and state)
10. Usual occupation: None
11. Industry or business: ✓
FATHER 12. Name: James D. Hunt
13. Birthplace: East Aurora, New York.
MOTHER 14. Maiden name: Ethel Pigue
15. Birthplace: Newell, New York
16. Informant: Ray D. Lebeda
Address: 347 Clinton St., Buffalo N.Y.
17. Buried (Burial, cremation, or removal, Which?) Date thereof 7/10/45 (month) (day) (year)
Cemetery or crematory: St. Matthews
Location: West Seneca, New York.
18. Funeral director: De Pilla Homes Co.
Address: Salisbury, Md.
19. 7/13 1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12, 1945, at 1.15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1945 to July 12 1945 and that I last saw her alive on July 12 1945

	DURATION
Immediate cause of death: Shock	1 hr.
Due to: Gangrene & obstruction of uterus	1 day
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Gangrene of 3 feet of intestine. Date of op. July 12-45
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademacher M.D. M. D. or other
Address: Salisbury, Md. Date signed: 7/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7-a

CERTIFICATE OF DEATH

07367

Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours
Hospital, institution, or street address where death occurred: R.D. #4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County:
City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5732 Larchwood, ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Alvin Gardner Culver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Etha Smith Culver
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Nov. 27th 1881

8. AGE: Years	Months	Days	If less than one day
63	8	1	..... hrs. ..... min.

9. Birthplace: Delmar Delaware (Town, county, and state)
10. Usual occupation: Postal Clerk
11. Industry or business: U.S. Gov.

FATHER
12. Name: William J. Culver (Wm. S.)
13. Birthplace: Delmar Delaware

MOTHER
14. Maiden name: Cordelia Ellen Hastings
15. Birthplace: Delmar Delaware

16. Informant: Mrs. Etha Smith Culver
Address: 5732 Larchwood ave. Phila. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31-1945 (month) (day) (year)
Cemetery or crematory: Delmar M.P. Cem.
Location: Delmar Delaware
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 7/30, 19 45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 45 at 10-15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 ..... and that I last saw deceased alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary Thrombosis	Instantaneous death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J.A. Rademaker, M.D. County Medical Examiner
M. D. or other
Address: Salisbury, Md. Date signed: 7/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07368

★ Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred: P. L. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thurman Heorne Dennis

3.(b) Social Security Number 216-07-2101

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elizabeth Davis Dennis

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): July 17, 1905

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
40	6	2		

9. Birthplace: Willard, Wicomico Co. Md
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Liquor Dispensary

FATHER
12. Name: John Murdy Dennis
13. Birthplace: Wicomico Co. Md

MOTHER
14. Maiden name: Ella M. Heorne
15. Birthplace: Wicomico Co. Md

16. Informant: Mrs. Thurman H. Dennis
Address: Pittsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/21/45 (month) (day) (year)

Cemetery or crematory: Pittsville Cemetery

Location: Pittsville Md

18. Funeral director: The Hill & Johnson Co

Address: Salisbury Md

19. 7/21/45 (Date rec'd by registrar) Harris C. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945; at 5 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1945 to July 19 1945 and that I last saw him alive on July 19 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 week
Due to	
Due to	
Other conditions: Gen. Arteriosclerosis, C. Pulmonale	

(Include pregnancy within 3 months of death)

Major findings of operations: Gen. Arteriosclerosis

Date of op. 7/13/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Date signed 7/20/45

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Rb-a)

CERTIFICATE OF DEATH

07369

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P. H. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: Sussex
City or town: Frankford
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Knox Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: (Lurenia) Lurenia Derrickson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife: James L. Derrickson
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 5-1861

8. AGE: Years	Months	Days	If less than one day
83	7	27	hrs. min.

9. Birthplace: Royanna Delaware (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: William Fickeman
13. Birthplace: Royanna Delaware

MOTHER
14. Maiden name: Eliza B. Morris
15. Birthplace: Royanna Delaware

16. Informant: Mr. William Derrickson
Address: Parsonsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5-45 (month) (day) (year)
Cemetery or crematory: Royanna Cem.
Location: Royanna Delaware

18. Funeral director: Willoughby & Walter R. Willoughby
Address: Salisbury maryland.

19. 7/6 19 45 Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2nd 1945 at 8.40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 28 1945 to July 2 1945 and that I last saw h alive on July 2 1945

	DURATION
Immediate cause of death: Chr. Duct Rect.	2 mo
Due to: Chr. Int. Nephri	6 mo
Due to: Hypertension	10 yr
Other conditions: Fractured Hip	3 mo.

Due to Accidental Fall. (Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of June 1st, 1945
Where did injury occur? Salisbury (City or town) Wicomico (County) Maryland (State)
Injured at home, farm, industry, public place (where?): At home.
Means of injury: Accidental Fall. Injured at work?

23. SIGNATURE: W. O'Day M.D. M. D. or other
Address: Salisbury Md. Date signed: 7/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1792)

07370

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 hrs
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 36 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Laurel RFD #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Dew, Jessie. Jr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single.

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.): July 2 1944

8. AGE: Years 1 | Months 5 | Days 22 | If less than one day ✓ hrs. ✓ min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Lumper (None)
11. Industry or business: ✓
FATHER 12. Name: Jessie Dew Sr.
FATHER 13. Birthplace: Del
MOTHER 14. Maiden name: Lucie Lowery
MOTHER 15. Birthplace: Md
16. Informant: Lucie L Dew
Address: Laurel Del RD 3
17. Burial (Burial, cremation, or removal? Which?) Date thereof June 29-45 (month) (day) (year)
Cemetery or crematory: Parsonage Cemetery
Location: Shawtown Md RD
18. Funeral director: J. Harvey Williamson
Address: Fredericksburg Md
19. 7/29 1945 Barbara E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-26 1945 at 9 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw ... alive on ... 19 ...

Immediate cause of death	DURATION
Lye poisoning	36 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 7-25-45
Where did injury occur? Laurel RFD 3 (City or town) Sussex (County) Del (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Drank lye by accident Injured at work? No

23. SIGNATURE: Deputy Med Examiner M.D. M. D. or other
Address: Salisbury Md Date signed: 7-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-b)

07371

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 months
Hospital, Institution, or street address where death occurred: 312 Smith st
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Smith street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret C. Disharoon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 9th 1887

8. AGE:

Years	Months	Days	If less than one day
58	6	21	hrs. min.

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: Sales Lady
11. Industry or business: at Dept. Store

FATHER
12. Name: Mathias Disharoon
13. Birthplace: Allen Maryland

MOTHER
14. Maiden name: Ellen Wayman
15. Birthplace: Somerset Co. Maryland

16. Informant: Mrs. George R. Gulner
Address: 312 Smith st. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 10th 1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.

19. 8/10/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31st 1945 at 9.30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10 1945 to July 31 1945 and that I last saw h.. alive on July 31 1945

Immediate cause of death	DURATION
Pulmonary Edema, Acute	
Due to: Mitral Stenosis	
Due to: Rheumatic Heart Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Rivers Hanson M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 8/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

07372

CERTIFICATE OF DEATH

★

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:
Peninsula General Hosp.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Powellville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Thomas Donoway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Dellie Donaway

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1877

8. AGE: Years	Months	Days	If less than one day
67	6	10	....hrs. ....min.

9. Birthplace Wheatsville, Wor Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter & Barber

11. Industry or business

FATHER 12. Name George B Donoway.

13. Birthplace Md.

MOTHER 14. Maiden name Annie Adkins

15. Birthplace Md.

16. Informant Mr. Thomas Donoway.

Address Powellville Md.

17. Burial Date thereof 7/8/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns.

Location Powellville Md.

18. Funeral director Anna A Burbage.

Address Berlin Md.

19. 7/8 1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5 1945, at 10:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/20/45 1945, to 7/5/1945 1945 and that I last saw h.im alive on 7/5/1945 1945

Immediate cause of death	DURATION
Adenocarcinoma of Prostate	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations C & T Prostate

Date of op. 6/25/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O. H. York M. D. or other

Address Salisbury Date signed 7/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

07573

★ Reg. Dist. No. 270

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? June 6, 1945

Hospital, institution, or street address where death occurred:
E. S. Tb. Sanatorium

How long in hospital or institution? Since June 6, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 23 Baltimore Street
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Evans, Ernest Carroll

3. (b) Social Security Number: 213-09-4963

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Phoebe Evans

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Sept 20, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	26	..... hrs. ..... min.

9. Birthplace: Crisfield, Maryland
(Town, county, and state)

10. Usual occupation: Supt. Ship Yard

11. Industry or business

FATHER 12. Name: Lewis Stewart Evans

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Ann Riggin

15. Birthplace: Maryland

16. Informant: Mrs. Phoebe Evans

Address: Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/18/45 (month) (day) (year)

Cemetery or crematory: Sunny Ridge

Location: Crisfield, Md.

18. Funeral director: Howard H. Hubbard

Address: 306 Main St., Crisfield, Md.

19. 7/7/45 (Date rec'd by registrar) 19.... C. E. Collins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 19 45 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/16/44-11/24/44 19.... to .... 19.... and 6/6/45-7/16/45 that I last saw him alive on 7/16/45 19....

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Paul Tyler M.D. M. D. or other

Address: Salisbury Md. Date signed: 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07374

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wilomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about Ten years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wilomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Commerce St
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Bertha R. Parlowe

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a a	Married

6.(b) Name of husband or wife: Charles A. Parlowe

6.(c) If alive, give age: about 65 years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years: 66 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Parsonsburg md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home duties

MOTHER FATHER

12. Name: Samuel Ewell

13. Birthplace: Parsonsburg md

MOTHER

14. Maiden name: Maria Bishop

15. Birthplace: Parsonsburg md

16. Informant: Charles A. Parlowe

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1945 (month) (day) (year)

Cemetery or crematory: Glen Hill

Location: Parsonsburg

18. Funeral director: James H. Stewart

Address: Salisbury md

19. 7/14/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12, 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1945 to July 12, 1945 and that I last saw h.er alive on July 11, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mos.
Due to	
Due to	
Other conditions: Diabetes Mellitus	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: G. H. Lembly M.D. M. D. or other

Address: Salisbury, Md. Date signed: 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH ★

07375

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Delaware St
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Fannie M Gandy

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a-a	widow

6.(b) Name of husband or wife: Raymond Gandy

Widow 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1-97

8. AGE:

Years	Months	Days	If less than one day
about 78	—	—	..... hrs. ..... min.

9. Birthplace: Salisbury md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER 12. Name: Emory Burkhead

13. Birthplace: Rockawalkin md

MOTHER 14. Maiden name: Martha Rider

15. Birthplace: Salisbury md

16. Informant: Mrs Martha J Burkhead

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15 1945 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury Md

18. Funeral director: Jarrett W Stewart

Address: Salisbury md

19. 7/11/45 (Date received by registrar) Fannie E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 19 45 at 1025A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 45 to July 10 19 45 and that I last saw h- alive on July 10 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: J D Brasure M D, M. D. or other

Address: Salisbury Md Date signed July 10

07376

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Harmon

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1885

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace Eden, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Artie Barclay
13. Birthplace Eden, Maryland

MOTHER
14. Maiden name
15. Birthplace

16. Informant Emily Norman

Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1945 (month) (day) (year)

Cemetery or crematory Flowers Hill Cemetery

Location Eden Maryland

18. Funeral director White Washington

Address Princess Anne Md

19. 7/3 1945 Blanche E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945 to July 2, 1945 and that I last saw h[illegible] alive on July 1, 1945

Immediate cause of death	DURATION
Carcinoma	2 years
Due to: Primary carcinoma of uterus & cervix	
Due to: Duration - two years	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. H. Lemby M.D.
M. D. or other

Address Salisbury Md. Date signed 7/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8 (a)

CERTIFICATE OF DEATH

07378

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: U. S. Dept.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Eden
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nettie Hayman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Ottis J. Hayman
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Sept. 23-1889

8. AGE: Years: 55 | Months: 9 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: R.D. Eden Md.
(Town, county, and state)

10. Usual occupation: U.S. Mail Carrier

11. Industry or business:

FATHER
12. Name: Josiah W. Pollitt
13. Birthplace: R.D. Eden, Md.

MOTHER
14. Maiden name: Margaret R. Hayman
15. Birthplace: Near Princess Anne Md

16. Informant: Mr. Jesse M. Pollitt
Address: Salem Md.

17. Buried (Burial, cremation, or removal, which?) Date thereof July 8-45 (month) (day) (year)
Cemetery or crematory: Salem Cem.
Location: Allen Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 7/7 1945 Received & Johnson Asst Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6th 1945, at 3:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1945, to July 6 1945 and that I last saw h alive on July 6 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 hr.
Due to: Hypertension	2 yrs
Due to: Arterio - Sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. O. Daly M.D.
M. D. or other
Address: Salisbury Date signed 7/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

(1)

(T)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

0737

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: P.B. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 Dover St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lottie Rebecca Hearn

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Vaughn S. Hearn
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): April 22 1906
8. AGE: Years 39 Months 2 Days 11 If less than one day ..... hrs. ..... min.
9. Birthplace: Chincoteague Va. (Town, county, and state)
10. Usual occupation: Operator at
11. Industry or business: Shirt Factory
FATHER 12. Name: George L. Pruitt
13. Birthplace: Virginia
MOTHER 14. Maiden name: Katie Pointer
15. Birthplace: Chincoteague Va.
16. Informant: Mr. Vaughn S. Hearn
Address: 127 Dover St, Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6-45 (month) (day) (year)
Cemetery or crematory: Parsons Mem.
Location: Salisbury Md
18. Funeral director: Gillis & Co. Walter R. Tho
Address: Salisbury Md
19. 7/6/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1945 at 9:15 P.M.
21. I CERTIFY that death occurred on the date above stated: That I attended deceased from July 3 1945, to July 3 1945
and that I last saw h... alive on July 3 1945
Immediate cause of death: Cerebral Hemorrhage, (Rt. Temporal Lobe)
DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: none
Date of op.
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. River Hanson, M.D.
M. D. or other
Address: Salisbury, Md. Date signed 7/3/45

Evidence for addition of sex & color of deceased is shown on FILM No. G97 AUG 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (730)

CERTIFICATE OF DEATH

07380

Reg. Diat. No. 337

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Fairmount

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur Johnson

3.(b) Social Security Number: 219-14-4151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife: Minnie Johnson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 61 | Months: about | Days: | If less than one day: hrs. min.

9. Birthplace: Fairmount Somerset Co. Md. (Town, county, and state)

10. Usual occupation: seafood workes

11. Industry or business: Oyster

FATHER 12. Name: John Johnson

FATHER 13. Birthplace: Fairmount Somerset

MOTHER 14. Maiden name: Emma

MOTHER 15. Birthplace: Somerset Co

16. Informant: Morton Workes

Address: Fairmont Md.

17. Burial, cremation, or removal. Which?: burial Date thereof: 7/31/45 (month) (day) (year)

Cemetery or crematory: Union Memorial

Location: Fairmont Md.

18. Funeral director: Chas H Heard

Address: Marion Md

19. (Date rec'd by registrar): July 30 1945 P. Woolford Mallett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-29 1945 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-28 1945, to 7-29 1945

and that I last saw h[illegible] alive on 7-28 1945

Immediate cause of death	DURATION
Acute Pulmonary edema	4-5 hrs.
Due to: Cardiac failure	
Due to: Rheumatic & Arteriosclerotic hypertensive heart disease	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William V. Lawson Jr M.D. M. D. or other

Address: Lon D. Allyn Fields M.D. Pocomoke Maryland Date signed: 7-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

07381

CERTIFICATE OF DEATH

Reg. Diat. No. 333

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution or street address where death occurred: RD #3. (Dellmar Road)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother.)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RD. #3 (Dellmar Road)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Amanda Jane Kelley

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Charles R. Kelley
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): Sept 19 1883
8. AGE: Years: 61 Months: 10 Days: 11 If less than one day: ....hrs. ....min.
9. Birthplace: Somerset Co. Princess Anne Md. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: at Home
FATHER 12. Name: Frank Biddle
FATHER 13. Birthplace: Princess Anne Md.
MOTHER 14. Maiden name: Jane Poole
MOTHER 15. Birthplace: Princess Anne Md.
16. Informant: Mrs. Willie Smith
Address: RD #3. Salisbury Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2 1945 (month) (day) (year)
Cemetery or crematory: Friendship Cem.
Location: Somerset Co. Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland
19. 8/2 1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31st 1945 at 2. P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15 1945 to July 31 1945 and that I last saw h.. alive on July 31 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	6 hrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. Wanner M. D.
M. D. or other
Address: Salisbury Date signed: Aug 1

Evidence for change of usual residence of deceased is shown on FILM No. G 97 AUG 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07382

CERTIFICATE OF DEATH ★

Reg. Dist. No. 335

1. PLACE OF DEATH:
County: Hiscomico
City or town: Sharptown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)
State: Md New Jersey Wic
County: Wic
City or town: Sharptown City of Camden (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William J. Kinitkin

3.(b) Social Security Number: 147-12-5858

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Victoria Kinitkin
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Oct 25 1878

8. AGE:

Years	Months	Days	If less than one day
66	8	16	hrs. min.

9. Birthplace: Sharptown Wic Md (Town, county and state)
10. Usual occupation: Merchant
11. Industry or business:

FATHER
12. Name: Levin J. Kinitkin
13. Birthplace: Md

MOTHER
14. Maiden name: Nancy E. Graham
15. Birthplace: Del

16. Informant: Victora Kinitkin
Address: 120 N 3rd St Camden N.J.

17. Burial, cremation, or removal: Burial Date thereof: 7-15-1945 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown
16. Funeral director: Graham Bros
Address: Sharptown

19. Date rec'd by registrar: Jul 12 1945 Walter R. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1945, at 8.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 11 1945 and that I last saw h. alive on July 11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 years
Due to: Arteriosclerosis	19 years
Due to:	
Other conditions: Uremic Coma	2 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please nuderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuckleman M. D.
M. D. or other
Address: Sharptown Md Date signed: 7/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

★ 07383

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Bradd

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Leah Jane Leonard

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	widow

6.(b) Name of husband or wife: John Leonard dead

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1868

8. AGE: Years	Months	Days	If less than one day
about 77	—	—	....hrs. ....min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Kathryn Brewington

MOTHER 15. Birthplace: Salisbury Md

16. Informant: Mr. Howard Leonard

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8 1945 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury Md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 7/8 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 2 1945, to July 5 1945

and that I last saw h.e.r. alive on July 5 1945

Immediate cause of death	DURATION
Arterio-Sclerosis	4 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Arthur L. Browne M. D. or other

Address: Salisbury Md Date signed 7/6/45

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH ★

07384

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
P.B. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: E. Isabella St. (Ward apts.)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joyce Ann Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 4-1945

8. AGE: Years | Months | Days: 1 | If less than one day: hrs. min.

9. Birthplace: P.B. Hoyt. Salisbury Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Roy J. Lewis
13. Birthplace: Salisbury Md.

MOTHER
14. Maiden name: Nellie Ford
15. Birthplace: Dames Quarter Md.

16. Informant: Mr. Roy J. Lewis
Address: E. Isabella St. (Ward apts.) Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7-1945 (month) (day) (year)
Cemetery or crematory: Wico. Mem. Park
Location: Salisbury Maryland
18. Funeral director: Hillman & Co. Walter R. Hillman
Address: Salisbury Maryland.

19. 7/7 1945 Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5th 1945 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1945 to July 5 1945 and that I last saw h[illegible] alive on July 5 1945

Immediate cause of death	DURATION
(a) Pneumonia	
Due to	
Due to	
Other conditions: Atelectasis Enlarged Thymus	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Rivers Hanson M.D.
M. D. or other
Address: Salisbury, Md. Date signed 7/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32nd)

CERTIFICATE OF DEATH

07385

Reg. Dist. No. 323

1. PLACE OF DEATH:
County: Wicomico
City or town: Eden (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred: R.D. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Eden (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Columbus McGee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie L. McGee
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): April 23-1886

8. AGE: Years	Months	Days	If less than one day
59	2	20	...hrs. ...min.

9. Birthplace: Westover Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Charles Henry McGee
13. Birthplace: R.D. Georgetown Delaware

MOTHER
14. Maiden name: Addie Frances Rose
15. Birthplace: Somerset Co. Maryland

16. Informant: Mrs. Elsie L. McGee
Address: R.D. #1. Eden, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: July 15-43 (month) (day) (year)
Cemetery or crematory: Quad Point Cem.
Location: Quad Point Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 7/15, 1943 (Date rec'd by registrar) Charles E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13th 1943, at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, 19..., to July 13 1943
and that I last saw him alive on April 1 1943

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M.D. or other
Address: Salisbury Date signed: July 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 47385 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred: ~~Same~~
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gertrude E. Mitchell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem'l	White	married

6.(b) Name of husband or wife: Ernest F Mitchell
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): Oct. 16. 1878

8. AGE: Years: 68 | Months | Days | If less than one day: ....hrs. ....min.

9. Birthplace: Willards Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Benjie Dennis
13. Birthplace: Md.
MOTHER 14. Maiden name: Amelia Dennis
15. Birthplace: Md
16. Informant: Mr Ernest Mitchell
Address: Willards Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 1945 (month) (day) (year)
Cemetery or crematory: Dennis
Location: Willards Md
18. Funeral director: M. Parks Watson
Address: Selbyville, Del.
19. 9/3 1945 (Date rec'd by registrar) Lillian R. Davis Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to July 1 1945 and that I last saw her alive on July 1, 1945

Immediate cause of death	DURATION
Carcinoma of Cervix	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L Phicel M. D.
M. D. or other
Address: Berlin, Md Date signed 9/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-1)

CERTIFICATE OF DEATH

17387

★ Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Allen, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME: Moore, George

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs. Julia A. Moore

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Sept 29, 1860

8. AGE:

Years	Months	Days	If less than one day
84	10	2	hrs. min.

9. Birthplace: Portsville, Md.
(Town, county, and State)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Samuel Moore

FATHER — 13. Birthplace: Portsville, Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace

16. Informant: Mrs Aline Fields

Address: Hampton, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 3, 1945 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Mt Vernon, Md.

18. Funeral director: Dale Dashiell

Address: Princess Anne, Md.

19. 8/2/45 (Date rec'd by registrar) Harriet E. Dashiell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 - 31 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 - 20 1945, to 7 - 31 1945 and that I last saw h... alive on July 31 1945

Immediate cause of death	DURATION
Senility and	
chronic myocarditis	
Due to with decompensation	1 week
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Pademelon MD M. D. or other

Address: Salisbury, Md. Date signed 7/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07388

★ Reg. Dist. No. 329

1. PLACE OF DEATH:

County Worcester

City or town Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Newark

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mumford, Mr John W.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

8.(b) Name of husband or wife Mumford, Mrs Grace

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 7, 1877

8. AGE: Years	Months	Days	If less than one day
68	3	16	...hrs. ...min.

9. Birthplace Newark, Wor Co. Md. (Town, county, and state)

10. Usual occupation Retired Broker

11. Industry or business

FATHER 12. Name Thomas N. Mumford

13. Birthplace Maryland.

MOTHER 14. Maiden name Catherine Nicholson

15. Birthplace Md.

16. Informant Mrs. John W. Mumford

Address Newark Md

17. Cremated (Burial, cremation, or removal. Which?) Date thereof 7/25/45 (month) (day) (year)

Cemetery or crematory Bowen

Location Newark Md

18. Funeral director Anna A. Bunting

Address Berlin Md.

19. 7/26/45 (Date rec'd by Registrar) 19 45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23 19 45 at 1:08 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-15 19 45 to 7-23 19 45 and that I last saw h. alive on 7-22 19 45

	DURATION
Immediate cause of death Generalized Peritonitis	
Due to Gangrenous ruptured appendix	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations General peritonitis Gangrenous appendix Date of op. 7-15-45

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Rademaker M.D. M. D. or other

Address Salisbury, Md Date signed 7/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23rd)

CERTIFICATE OF DEATH

07389

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Pittsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Pittsville Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary E. Mutschler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Wm. R. Mutschler

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 22 1876

8. AGE: Years	Months	Days	If less than one day
69	2	4	hrs. min.

9. Birthplace: Greenwich Conn. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John H. Sally
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Anne Hamilton
15. Birthplace: Greenwich Conn.

16. Informant: Gladys Mutschler
Address: Pittsville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof aug 1 1945 (month) (day) (year)

Cemetery or crematory: Union Cem.

Location: Greenwich Conn.

18. Funeral director: C. D. Pennewill

Address: Pittsville Md

19. July 31 1945 (Date rec'd by registrar) P. Wolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 2.20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1945 to July 28th 1945 and that I last saw h... alive on July 27 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William Emrich M. D. or other

Address: Helen Md Date signed: July 28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BF6)

CERTIFICATE OF DEATH

07390

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 day - 12 hrs. 50 mins.

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 4 day - 12 hrs. 50 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Bishopville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Padgett, Herman

3.(b) Social Security Number: Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
48				

9. Birthplace: Florida (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Daisy Porter

Address: Bishopsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-27-45 (month) (day) (year)

Cemetery or crematory: Public Cemetery

Location: Salisbury Maryland

18. Funeral director: ~~402 E.~~ James F. Stewart

Address: 402 E. Church St. Salisbury, Md.

19. 7/27/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-24 1945 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/19 1945 to 7/24 1945 and that I last saw h[illegible] alive on 7/24 1945

Immediate cause of death	DURATION
Thrombus Cerebral	5 days
Due to: Chronic Nephritis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Md. Date signed 7/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

07391

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Month
Hospital, Institution, or street address where death occurred: 415 Davis St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Davis St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wilmer Pallitt
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept 2, 1869
8. AGE: Years 75 Months 10 Days 21 If less than one day ... hrs. ... min.
9. Birthplace Wicomico co, Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Andrew Pallitt
13. Birthplace Wicomico co, Md

MOTHER
14. Maiden name Virginia Anderson
15. Birthplace Wicomico co Md

16. Informant Wicomico co. Welfare
Address Salisbury Md
17. Burial Date thereof 7/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md.
18. Funeral director The Hill & Fuhrmann
Address Salisbury, Md
19. 7/25, 19 45 Harriet E. Johnson, Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... except medical examiner
and that I last saw him alive on ... 19 ...

	DURATION
Immediate cause of death Chronic myocarditis; duration one year	one year
Due to cause with cardiac decompensation	6 weeks
Due to Old age; arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE J. A. Vandersloot MD, Deputy Med. Examiner
M. D. or other
Address Salisbury Md
Date signed 7/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

CERTIFICATE OF DEATH ★

07392

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 7/6/45 to 7/7/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Newark

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. William Z. Powell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Mamie Powell

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) November 20, 1871

8. AGE:

Years	Months	Days	If less than one day
73	7	17	....hrs. ....min.

9. Birthplace Newark, Wor. Co. Md.

(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER 12. Name William Z. Powell.

13. Birthplace Newark, Wor. Co. Md.

MOTHER 14. Maiden name Jannie Jackson

15. Birthplace Md.

16. Informant Mrs. William Z. Powell

Address Newark Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/10/1945 (month) (day) (year)

Cemetery or crematory Bowen Cemetery

Location Newark Md.

18. Funeral director Anna F. Burbage

Address Berlin Md

19. 7/10/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 1945, at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/6 1945, to 7/7 1945 and that I last saw her alive on 7/7 1945

Immediate cause of death	DURATION
Hypertensive Heart Disease	Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Mills M. D. or other

Address Salisbury Md. Date signed 7/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45a)

CERTIFICATE OF DEATH

07393

★ Reg. Dist. No. 233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 C Month

Hospital, institution, or street address where death occurred:
201 N. Boulevard

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Tyaskin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Hilary Riall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	W Edowed

6.(b) Name of husband or wife: Ella P. Riall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 15, 1857

8. AGE: Years	Months	Days	If less than one day
87	6	21	..... hrs. ..... min.

9. Birthplace: Tyaskin Wicomico, Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John Riall
13. Birthplace: Tyaskin Md

MOTHER
14. Maiden name: Sarah Daughtry
15. Birthplace: Tyaskin Md

16. Informant: Pauline Riall
Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/8/45 (month) (day) (year)

Cemetery or crematory: St Mary Cemetery

Location: Tyaskin Md

18. Funeral director: The Hill & Johnson Co

Address: Salisbury Md

19. 7/8 1945 Elizabeth E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to July 6 1945 and that I last saw h.. alive on July 6 1945

Immediate cause of death	DURATION
Carcinoma of lower lip	3 yrs.
Due to	
Due to	
Other conditions: Hemolytic Ulcers	3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L A Rademaker MD
M. D. or other

Address: Salisbury Md Date signed 7/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

07394

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) Rural

How long in above place of death? 1 mo 12 days

Hospital, institution, or street address where death occurred: E.S. TB Sanatorium

How long in hospital or institution? 1 mo. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dionne May Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Geo Richardson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1896

8. AGE: Years	Months	Days	If less than one day
49	2	1	hrs. min.

9. Birthplace: Hallwood Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Amos T. Chesser

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Anne Murray

MOTHER 15. Birthplace: Virginia

16. Informant: deceased on Admission Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 26, 1945 (month) (day) (year)

Cemetery or crematory: Onancock

Location: Henry Virginia

19. Funeral director: J. Johnson [redacted]

Address: Parksley, Va.

19. 7/24/45 (Date rec'd by registrar) Harriet J. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1945, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/11/45 19.. to 7/23/45 19.. and that I last saw her alive on 7/23/45 19..

Immediate cause of death	DURATION
Congestive Cardiac Decompensation	2 mos.
Due to: Aortic insufficiency and mitral stenosis	unknown
Due to: Rheumatic heart disease	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M.D. M. D. or other

Address: Salisbury Date signed: 7/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

0739:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Near Mardela Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Mardela Md R.D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George H. Riggin

3.(b) Social Security Number: 213-24-0261

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Kate Riggin
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Oct 4 1878

8. AGE: Years	Months	Days	If less than one day
66	8		hrs. min.

9. Birthplace: Wic Md (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business
FATHER 12. Name: George H. Riggin
FATHER 13. Birthplace: Md
MOTHER 14. Maiden name: Rosie A. Twilley
MOTHER 15. Birthplace: Md
16. Informant: Mrs. Edward Bennett
Address: Mardela, Md.
17. (Burial, cremation, or removal) Burial Date thereof 7 6 1945 (month) (day) (year)
Cemetery or crematory: Athel
Location:
18. Funeral director: Groverman Bros
Address: 7/6/45 Sharptown Md
19. 7/6/45 19 W. H. Robertson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/4 1945 at 1-45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1945 to July 3 1945 and that I last saw him alive on July 3 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Helen Md. Date signed: July 4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

07396

CERTIFICATE OF DEATH

★Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Dorchester
City or town Rhodesdale Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Robinson, Mr Charles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Sharptown Wicomico Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Jethro Robinson
13. Birthplace Md

MOTHER 14. Maiden name Laura Bradley
15. Birthplace Md

16. Informant Frank Robinson
Address Federalsburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 23-1945 (month) (day) (year)
Cemetery or crematory M. P. Cemetery
Location Sharptown

18. Funeral director Graveyor Bros
Address Sharptown Md.

19. 7/23/45 (Date rec'd by registrar) Harriet L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 12-20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1945, to July 21 1945 and that I last saw h... alive on July 21 1945

Immediate cause of death	DURATION
Shock & Hemorrhage	1 hr
Due to Laceration of Rt thigh	2 hrs
Comp fracture Rt femur & ankle	
Due to Fracture Lt elbow	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: yes
Accident, suicide, or homicide accident Date of 7-20-45
Where did injury occur? Found - Sharptown Sussex Del
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Riding Bicycle Injured at work? no
Struck by car.

23. SIGNATURE Jake Lemmon M.D.
M. D. or other
Address Parksley Va Date signed 7-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

07397

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 30 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother).

State: md County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Alice Lethenbury Shepherd

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	married

6.(b) Name of husband or wife: Henry Shepherd

6.(c) If alive, give age: yes Don't know years

7. Birth date of deceased (mo., day, yr.): about 1868

8. AGE: Years: about 77 | Months: — | Days: — | If less than one day: ....hrs. ....min.

9. Birthplace: Quantico md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Domestic abroad

FATHER — 12. Name: Robert Bullard

FATHER — 13. Birthplace: Eastern Shore

MOTHER — 14. Maiden name: Eastin Anderson

MOTHER — 15. Birthplace: Quantico md

16. Informant: Henry Shepherd

Address: Salisbury md

17. Burial, cremation, or removal. Which?: Burial Date thereof: July 4 1945 (month) (day) (year)

Cemetery or crematory:

Location: Quantico

18. Funeral director: James H. Stewart

Address: Salisbury md

19. (Date rec'd by registrar) 7/2 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-1 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-30 1945, to 6-30 1945

and that I last saw her alive on 6-30 1945

Immediate cause of death	DURATION
Acute Heart Failure (congestive)	
Due to: Renal Damage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?): ....

Means of injury: ....Injured at work?

23. SIGNATURE: E. A. Purnell M.D. M. D. or other

Address: 200 W. Main St. Date signed: 7-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

07398

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 712 Lake St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Roxie Lena Smith

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: James Smith
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 24, 1867

8. AGE: Years: 78 | Months: 4 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Camden N. J.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housework
FATHER 12. Name: Benjamin Lawson
13. Birthplace: Del
MOTHER 14. Maiden name: Amelia Gilmore
15. Birthplace: Del
16. Informant: Julia Gibson
Address: 712 Lake St. Salisbury Md.
17. Burial, cremation, or removal. Which?: Burial Date thereof: July 15, 1945 (month) (day) (year)
Cemetery or crematory: Fullilla Chapel
Location: Whaleyville Md.
18. Funeral director: Mr. Pasha Watson
Address: Selbyville, Del.
19. 7/14, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945 to July 14 1945 and that I last saw h.e.r alive on July 14 1945

Immediate cause of death	DURATION
Chronic Nephritis	4 Yrs
Due to:	6 Mos
Due to:	
Other conditions: Uremic Coma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur D. Browne M. D. or other
Address: Salisbury Md. Date signed: 7/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

0739

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town: Near Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: R. D.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Near Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lillie Blanche Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife: Herman Taylor
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Oct. 2- 1889

8. AGE: Years: 55 | Months: 9 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Dorchester Co. Md.
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: at Home

FATHER
12. Name: William Jefferson Arnett
13. Birthplace: Dorchester Co. Maryland

MOTHER
14. Maiden name: Josephine Griffith
15. Birthplace: Dorchester Co Md.

16. Informant: Mr. Herman Taylor
Address: R.D.#1. Eden Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 8-45 (month) (day) (year)
Cemetery or crematory: Washington Mem.
Location: Hurlock Maryland

18. Funeral director: Holloway & Co. Walter K. Holloway
Address: Salisbury Maryland.

19. 7/7/45 (Date rec'd by registrar) Theresa E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5th 1945 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945 to July 5 1945 and that I last saw h.. alive on July 5 1945

Immediate cause of death	DURATION
Coronary Thrombosis	6 hr
Due to: C.V.D. Int. Nephritis	6 mo.
Due to: Hypertension	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. D. Davis M.D.
M. D. or other
Address: Fruitland Md. Date signed: 7/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51

07400

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days.

Hospital, institution, or street address where death occurred: Peninsula General Hospital.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Ocean City, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Balto. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Francis J. Townsend

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Rayne Townsend

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.): April 10, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	22	...hrs. ...min.

9. Birthplace: Snow Hill, Worcester, Md.
(Town, county, and state)

10. Usual occupation: M.D.

11. Industry or business: Medicine

FATHER
12. Name: Robert Townsend
13. Birthplace: Snow Hill, Md.

MOTHER
14. Maiden name: Susan Bowden
15. Birthplace: Snow Hill, Md.

16. Informant: Anna Rayne Townsend
Address: Ocean City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1945 (month) (day) (year)

Cemetery or crematory: M.E. Cemetery

Location: Snow Hill, Md.

18. Funeral director: Anna A. Bunbarger

Address: Pocomoke Md.

19. 7/4 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2d 1945, at 9.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/ 1945 to 7/2 1945 and that I last saw h... alive on 7/2 1945

Immediate cause of death	DURATION
Lobar Pneumonia	5 days
Due to	
Due to	
Other conditions: Carcinoma of Prostate	8 months

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Claude Fraser M.D. or other

Address: Salisbury Md. Date signed 7/2 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07401

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Hebron-town - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Tull, Gertrude C.

3.(b) Social Security Number: 219-07-7714

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B.(b) Name of husband or wife: George Tull
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): June 15, 1906

8. AGE:	Years	Months	Days	If less than one day
	39	1	7	...hrs. ...min.

9. Birthplace: Wicomico County, Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: — Gladden
13. Birthplace: Wicomico County, Maryland

MOTHER
14. Maiden name: Theodosia Staley
15. Birthplace: Wicomico County, Maryland

16. Informant: Herman Cook
Address: Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1945 (month) (day) (year)
Cemetery or crematory: Wetipquin Cemetery
Location: Wetipquin, Maryland

18. Funeral director: J. J. Trampton and Son
Address: Fruitvalesburg, Maryland

19. 7/24/1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 45 at 3 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-25 19 45 to 8-22 19 45 and that I last saw h...e...x... alive on 7-21 19 45

Immediate cause of death	DURATION
Myocardial disease with decompensation	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Rodenbo MD
M. D. or other
Address: Salisbury, Md Date signed 7/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-E)

07402

CERTIFICATE OF DEATH

★ Reg. Diat. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or Institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Seaford (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓ ✓

3. (a) FULL NAME: Watson-Mr. Medford S. Sr.

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	✓

6.(b) Name of husband or wife: Mrs. Mary K. Watson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 10, 1858

8. AGE:

Years	Months	Days	If less than one day
86	8	9	..... hrs. ..... min.

9. Birthplace: Roxana, Sussex, Delaware (Town, county, and state)

10. Usual occupation: Retired Funeral Director

11. Industry or business

FATHER 12. Name: Henry H. Watson

FATHER 13. Birthplace: Delaware

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: "

16. Informant: Mrs. Mary K. Watson

Address: Seaford, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1945 (month) (day) (year)

Cemetery or crematory: Odd Fellows

Location: Seaford, Delaware

18. Funeral director: Margarette H. Watson

Address: Pocomoke city, Md.

19. 7/20/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 19 45, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 45, to July 19 19 45 and that I last saw h[illegible] alive on July 19 19 45

Immediate cause of death	DURATION
Uremia	3 days
Due to: Hypertrophied Prostate	6 mos.
Due to: Chronic nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. P. Rademacher M D

M. D. or other

Address: Salisbury, Md. Date signed 7/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-a)

07403

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred: Salisbury Peninsula Gen Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war — ✓

3.(a) FULL NAME Watson Mrs. Viola

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Watson
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): January 2 - 1890

8. AGE: Years 55 | Months 6 | Days 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pocomoke, Worcester Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business —
12. FATHER Name: William Lewis
13. Birthplace: Md.
14. MOTHER Maiden name: Belle Bunting
15. Birthplace: Md
16. Informant: John Watson
Address: Pocomoke Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2 1945 (month) (day) (year)
Cemetery or crematory: Hall Hill Baptist
Location: Pocomoke Md.
18. Funeral director: Margarette E. Watson
Address: Pocomoke Md.
19. 7/30, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/30 1945, at 4 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/20 1945, to 7/30 1945 and that I last saw h... alive on 7/30 1945

Immediate cause of death	DURATION
Carcinoma of ovary	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Huge carcinoma of left ovary with metastases. Date of op. 7/16/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L.A. Rademaker M.D.
M. D. or other
Address: Salisbury Md Date signed: 7/30/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

117414

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn iofants give resideoce of mother)

State Maryland County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John S. White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	married

6.(b) Name of husband or wife Victoria White

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Won't Know 1872

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace Nanticoke, Md.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name John S. White

13. Birthplace Nanticoke, Md.

MOTHER 14. Maiden name Priscilla White

15. Birthplace Nanticoke, Md.

16. Informant Melvin White

Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11, 1945 (month) (day) (year)

Cemetery or crematory Cemetery

Location Jesterville, Md.

18. Funeral director G. E. Messick

Address Bivalve, Md.

19. July 10 1945 (Date rec'd by registrar) R. Wolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 8 1945 and that I last saw h alive on July 8 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Includo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or towo) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Emrich
M. D. or other

Address Hebron, Md. Date signed July 10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

07405

Reg. Dist. No. 331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James O. Wilson

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie M. Wilson
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): January 29, 1867
8. AGE: Years: 78 Months: 6 Days: Hours: Minutes: If less than one day
9. Birthplace: Wetipquin, Wicomico, Md. (Town, county, and state)
10. Usual occupation: Postmaster, retired
11. Industry or business:
FATHER 12. Name: William Wilson
13. Birthplace: Wetipquin Md.
MOTHER 14. Maiden name: Leonie Walter
15. Birthplace: Princess Anne Md.
16. Informant: Lennie Wilson
Address: Hebron Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/45 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury Md.
18. Funeral director: David T. Maguire
Address: Hebron Md.
19. July 29 1945 Mrs J. M. Wallace
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1945, at 11:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1945 to July 29th 1945 and that I last saw h... alive on July 28th 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions: arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Emerick, M. D. or other
Address: Hebron Md. Date signed: July 29 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74-a

CERTIFICATE OF DEATH

07406

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days - 52 min.

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 3 days - 52 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Accomack

City or town Chincoteague (If outside city or town limits, write RURAL and give nearest town)

Street No. 34 Church St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Weinbrow, Miss Edna Virginia

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1875.

8. AGE: Years 19 | Months 8 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Wilmington, Del. (Town, county, and state)

10. Usual occupation Secretary

11. Industry or business General Office

FATHER 12. Name Miller C. Stockham

FATHER 13. Birthplace Chincoteague, Va.

MOTHER 14. Maiden name Lelia M. Baker

MOTHER 15. Birthplace Chincoteague, Va.

16. Informant Mrs. Lelia B. Stockham

Address Chincoteague, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/45 (month) (day) (year)

Cemetery or crematory Pinewiew

Location Wilmington, Del.

18. Funeral director De Hill & Gibson Co.

Address Salisbury, Md.

19. 7/9 (Date rec'd by registrar) 1945 Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5 1945, at 8:58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1945, to 7-5 1945 and that I last saw h... alive on 7-3 1945

	DURATION
Immediate cause of death Leukemia	3 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.A. Rademaker M.D. M. D. or other

Address Salisbury, Md. Date signed 7-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15